ANDERSON SPECIFIC CHIROPRACTIC

1099 MERCHANTS DRIVE, SUITE B, DALLAS, GEORGIA 30132
PHONE: 770-443-4225 ~ FAX: 770-443-3890 ~ EMAIL: info@andersonspecific.com

INFORMATION

Name:_____ DOB:_____ Date:_____

Hm Phn:(___)_____ Wk Phn:(___)_____ Cell Phn:(___)_____

Address:_____

City:_____ State:_____Zip:_____ SS#:_____

Email:_____

Your Occupation:_____ Employer:_____

Marital Status: S M D W Spouse's Name:_____

Spouse's Occupation:_____ Spouse's Employer:_____

Spouse's Work Phone:(_____)_____ Nearest Friend or Relative:_____

Insured's Name:_____ Insured's DOB:_____ Insured's SS#:_____

Insured's Address:_____

Number of Children and Ages:_____ Have You Ever Received Chiropractic Care? _____

Sleeping Posture: Side Stomach Back (circle all that apply) Date of onset/accident:_____

Description of Accident/Injury/Onset:_____

Please tell us your condition during and after the accident /onset:_____

Who may we thank for referring you to our clinic? _____

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Present major complaint:_____ Date symptom began:_____
Other Symptoms:

___Fever
___Headaches
___Sleeping Problems
___Cold Sweats
___Lights bothers eyes
___Nervousness
___Eye Pain
___Irritability
___Loss of weight
___Dizziness
___Nose bleeds
___Allergy
___Frequent colds
___Sinus infections
___Nasal drainage
___Stiff neck
___Tremors
___Faulty posture
___Colitis

___Chronic pain
___Hernia
___Difficult breathing
___Rapid heart beat
___Crossed eyes
___High blood pressure
___Deafness
___Earaches
___Ear noises
___Swelling of the ankle
___Sore throat
___Enlarged thyroid
___Neck pain
___Back pain
___Jaundice
___Pain over stomach
___Painful tailbone
___Constipation
Loss of memory

___Slow heart beat
___Low blood sugar
___Low blood pressure
___Blood in urine
___Feet cold
___Hands cold
___Poor circulation
___Tonsillitis
___Fatigue
___Depression
___Liver trouble
___Colon trouble
___High blood sugar
___Frequent urination
___Face flushed
___Bedwetting
___Hardening of the arteries
___Kidney infection/stones
___Pins & needles in leg/feet

__Pins & needles in arms/hands
__Inability to control urine
__Gall bladder trouble
__Prostate trouble
__Itching
__Fainting
__Wheezing
__Asthma
__Poor appetite
__Excessive hunger
__Difficult digestion
__Numbness in fingers
__Numbness in toes
__Chest pain
__Belching or gas
__Nausea
__Vomiting
__Loss of balance
__Swollen joints

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LOSS OF WELLNESS

Let's begin when you first damaged your nerve system, lost your wellness, and began your journey to ill health.

Growth and Development

YES NO
___ ___Accidents?
___ ___Were you taught to care for your spine?
___ ___Did you play contact sports?
___ ___Childhood sicknesses?
___ ___Did you have Traumas? What? When?
_____

Current Health Habits

YES NO
___ ___ Do you smoke?
___ ___ Do you drink any alcohol?
___ ___ Have you been in accidents?
___ ___ Physical stress/Mental Stress?
___ ___ Prescriptions?
___ ___ Over-the-counter drugs?

Other health concerns: _____

Have you ever been under drug and medical care? _____ Please describe:_____

What prescriptions and over-the-counter medications are you taking? _____

How long have you been taking these medications? _____

Have you had surgery? _____ What type? _____ When?_____

What side effects have you experienced from drugs and surgery? _____

_____

Is there a family history of: Heart disease Arthritis Cancer Diabetes Other_____

Father's side: _____ _____ _____ _____ _____

Mother's side: _____ _____ _____ _____ _____

For our female patients, is there any possibility you are or may be pregnant? ___Yes ___No

Date of LMP (last period): _____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra of the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____have read and fully understand the above statements
(Print Name)

ASSIGNMENT OF BENEFITS: I hereby instruct and direct my insurance company to pay by check payable to and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. I understand that I am fully responsible for the mutually agreed upon health fee between this clinic and myself. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____
(Signature) (Date)

RELEASE OF INFORMATION: In accordance with HIPPA regulations, I authorize this clinic to release any information necessary to process this claim.

_____ _____
(Signature) (Date)